

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6471

## CERTIFICATE OF DEATH

Reg. Dist. No. 06480 60

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Goldsboro</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Goldsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Enoch</u> (Middle) <u>E.</u> (Last) <u>Baker</u>		(Month) <u>7</u> (Day) <u>18</u> (Year) <u>55</u>	
5. SEX: <u>Male</u>		6. AGE last birthday <u>83</u> yrs.	
7. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>10/16/1871</u>	
9. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <u>Retired Farm Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank Baker</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Dhue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Rosa Baker Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Organic Heart (Valvular)</u>		<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) <u>Neurathic Arteritis</u>		<u>20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Infected Teeth</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1945 to July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>55</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. H. Sever</u>		DATE SIGNED <u>7/19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/20/55</u>		REGISTRAR'S SIGNATURE <u>J. E. Boulois</u>	
FUNERAL DIRECTOR ADDRESS <u>Greensboro, Md.</u>			

BUREAU V. S.

AUG 8 1965

RECEIVED

6472

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Denton</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>MAUDE</u> (Middle) (Last) <u>EIKE</u>		4. DATE OF DEATH: (Month) <u>JULY</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 14, 1875</u> 79 yrs.
9. AGE last birthday: <u>17</u> UNDER 1 YEAR <u>17</u> UNDER 24 HRS.		10. DATE OF BIRTH: <u>Dec 14, 1875</u> 79 yrs.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Brewer</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Packberry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>Eugene Eike, Denton, Md.</u>	
17. INFORMANT & ADDRESS: <u>Eugene Eike, Denton, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
334X Immediate cause (a) <u>arterio sclerosis</u> DUE TO		10 years	
Antecedent causes (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) <u>Left sided hemiplegia</u>		4 1/2 years	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>mixed chronic diabetes</u>		1 years	
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 7, 1947</u> to <u>July 23, 1955</u> , that I last saw the deceased alive on <u>July 23, 1955</u> , and that death occurred at <u>9:30 pm</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul K. H. H. H.</u> (Degree or title)		DATE SIGNED <u>7-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Alpine</u>		LOCATION (City, town, or county) (State) <u>North Ambury, N.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/25/55</u>		REGISTRAR'S SIGNATURE <u>Wm. O. George</u>	
24. FUNERAL DIRECTOR <u>John D. Moore, Jr., Baltimore, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 29 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06482

6473

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Denton</u>		<u>50 Yrs.</u>		TOWN <u>Rural Denton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>None</u>				<u>None</u>			
3. NAME OF DECEASED:			4. DATE OF DEATH:				
(First) (Middle) (Last)			(Month) (Day) (Year)				
<u>Hattie Lister</u>			<u>7 5 55</u>			<u>19</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED:		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>3/13/1880</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>75</u> yrs.		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>				<u>None</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Christopher Hammer</u>				<u>Sarah Christpher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>J. Walter Lister Denton, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>chronic coronary insufficiency</u>						<u>18 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension and arteriosclerosis</u>						<u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 195 <u>4</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 14</u> , 19 <u>55</u> , and that death occurred at <u>3 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Paul North</u>				ADDRESS <u>Denton Md</u>		DATE SIGNED <u>7-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>7/7/55</u>		<u>Grace Lawn Park</u>	
24. FUNERAL DIRECTOR				ADDRESS			
<u>Wm D O George</u>				<u>J E Boulain Greensboro, Md.</u>			

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JUL 15 1955

BUREAU V. B.



## CERTIFICATE OF DEATH

Reg. Dist. No. 62

6474

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Denton</u>		RURAL LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>CATHERINE LOUISE PINE</u>				4. DATE OF DEATH: (Month) <u>JULY</u> (Day) <u>13</u> (Year) <u>55</u>			
5. SEX: <u>7</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Aug. 7, 1913</u>	
9. AGE last birthday: <u>41</u> yrs.		10. MONTHS: <u>4</u>		11. DAYS: <u>13</u>		12. HOURS: <u>19</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>house</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>William B. Collison</u>			
14. MOTHER'S MAIDEN NAME: <u>Aurice Colles</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>			
16. SOCIAL SECURITY No.: <u>9</u>				17. INFORMANT & ADDRESS: <u>Arthur Pine, Denton Ind.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause <u>592X</u> (a) <u>Coronary Occlusion</u>						<u>2 hours</u>	
Antecedent causes (s) (b) <u>Hypertension</u>						<u>4 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Chronic Glomerulonephritis</u>						<u>7 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>8</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-15</u> , 19 <u>50</u> , to <u>7-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>53</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John D. O. George</u> (Degree or title) <u>EST.</u>				DATE SIGNED <u>July 14, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>July 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/14/55</u>		REGISTRAR'S SIGNATURE <u>John D. O. George</u>		24. FUNERAL DIRECTOR <u>George J. George</u>		ADDRESS <u>1000 N. 1st St., Denton, Ind.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 20 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06484

6475

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Caroline</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Federalsburg</b>		LENGTH OF STAY (in this place) <b>11 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Federalsburg</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>100 Park Lane</b>				STREET ADDRESS (If rural give location) <b>Park Lane</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Cape Hattress Reagan</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>July 10 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>W hite</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>July 19, 1876</b>	9. AGE last birthday <b>78</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country): <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME: <b>William F. Reagan</b>				14. MOTHER'S MAIDEN NAME: <b>Alice Wheatley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-22-4916</b>		17. INFORMANT & ADDRESS: <b>Mrs. Nannie S. Reagan, Federalsburg, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>447X Cardiac Failure</b>						<b>7-5-710-5</b>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (A) <b>Generalized Atherosclerosis - C</b>						<b>9-27-44</b>	
DUE TO (B) <b>Hypertension</b>							
DUE TO (C) <b>Hypertension</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9-27</b> , 19 <b>54</b> , to <b>7-10</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>7-8</b> , 19 <b>55</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>W. E. German</b> ADDRESS <b>Federalsburg, Maryland</b> DATE SIGNED <b>7/11/55</b> M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>July 13, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>July 12, 1955</b>		REGISTRAR'S SIGNATURE <b>Margaret K. Frampton</b>		24. FUNERAL DIRECTOR ADDRESS <b>J.J. Frampton and Son, Federalsburg, Md.</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6475  
CERTIFICATE OF DEATH

06485

Reg. Dist. No. 66

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural Ridgely</u> LENGTH OF STAY (in this place) <u>5 Yrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STATE <u>Maryland</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Ridgely</u> <u>X</u> STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) (Middle) (Last) <u>Sister M. Florian Spiegl</u>		(Month) (Day) (Year) <u>7 18 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>5/21/1904</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday
<u>School Teacher</u>		<u>None</u>	<u>51</u> yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Simon Spiegl</u>		<u>Elizabeth Bohn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mother Hildagard Ridgely, Md.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		<u>30 mo.</u>	
ANTECEDENT CAUSE (S)		(A) <u>Carcinoma Breast with</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO	
		(B) <u>Metastases to abdominal viscera.</u>	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
<input type="checkbox"/>		<input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (City, or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 14, 1954</u> , to <u>July 18, 1955</u> , that I last saw the deceased alive on <u>July 16, 1955</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>J. E. Boulais</u>		<u>7-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St. Gertrudes</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>7/21/55</u>		<u>Ridgely, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		FURNERAL DIRECTOR ADDRESS	
<u>July 20, 1955</u>		<u>J. E. Boulais Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. RUTLAND

GRAND JURY

1895

## CERTIFICATE OF DEATH

Reg. Dist. No.

66

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Ind.</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Ridgely</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and give nearest town) <u>Ridgely</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <u>Anna</u> (Middle) <u>Temple</u> (Last) <u>Swing</u>		4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>July 14, 1869</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>86</u> yrs. <u>1</u> months <u>1</u> days <u>0</u> hours <u>0</u> min.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Temple</u>		14. MOTHER'S MAIDEN NAME: <u>Daguis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>17</u>	
17. INFORMANT & ADDRESS: <u>Mulford Swing, Easton.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <u>Cerebral vascular accident</u>		<u>5 days</u>	
Antecedent causes (s) (b) <u>Atherosclerosis, Generalized and cerebral arteriosclerosis</u>		<u>years.</u>	
DUE TO (c) <u>and cerebral arteriosclerosis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 19, 1955</u> , to <u>July 19, 1955</u> , that I last saw the deceased alive on <u>July 19, 1955</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Winickoff, M.D.</u>		DATE SIGNED <u>July 20, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Creek Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 20, 1955</u>		FUNERAL DIRECTOR <u>Virgil Moore &amp; Son, Deer Creek</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. C. 1000

11 1000



6478

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## I. PLACE OF DEATH:

COUNTY

*Baltimore*

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

*Denton*

LENGTH OF STAY (in this place)

*40 hrs*

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

*Maryland*

COUNTY

*Baltimore*

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

*Denton*

STREET ADDRESS

(If rural give location)

*Say Street*

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

*Mollie Elizabeth Thomas*

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

*July - 20 - 1955*

## 5. SEX:

*F*

## 6. COLOR OR RACE:

*W.*

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

*Widow*

## 8. DATE OF BIRTH:

*June 11 - 1896**79 yrs.**Months**Days**Hours**Min.*

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)

*Stenographer*

## 10b. KIND OF BUSINESS OR INDUSTRY:

*Maryland*

## 11. BIRTHPLACE (State or foreign country)

*U.S.A.*

## 13. FATHER'S NAME:

*William Wright*

## 14. MOTHER'S MAIDEN NAME:

*Eliza Jane Atterbridge*

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

*Y*

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT'S ADDRESS:

*Mrs. Colvin Rae, Denton, Md.*

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

*151X Immediate cause**Carcinoma of Stomach*

## Antecedent causes (s)

*Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.**DUE TO**(c)*

## II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.**Cardio Vascular Disease (arteriosclerosis)*

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death  
*8 mos.*

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

*(Specify)*

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

*m.*

## INJURY OCCURRED

While at Work

Not While At Work

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct 10, 1954*, to *July 20, 1955*, that I last saw the deceased*alive on July 19, 1955, and that death occurred at July 20**(Degree or title)**from the causes and on the date stated above.*

SIGNATURE

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, or other disposal (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FEDERAL DIRECTOR

ADDRESS

*7/23/55**Dr. D. C. Jones**George J. Higginbotham**Denton*

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 29

1968

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6473

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07579

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Federalsburg - Rural</u>	<u>Life</u>	OR TOWN <u>Federalsburg - Rural</u>	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>American Corner</u>		STREET ADDRESS (If rural give location) <u>American Corner</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Francis Henry Trice</u>		<u>July 28 19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 21, 1880</u>	
9. AGE last birthday <u>75</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country): <u>Caroline County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Silas A. Trice</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Warren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Mary R. Trice, Federalsburg, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>191X</u>		<u>Mar 1955</u>	
ANTECEDENT CAUSE (B):		<u>July 22 1955</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>1953</u>	
(A) <u>Metastatic Carcinoma</u>			
DUE TO <u>Liver &amp; Colon</u>			
(B) <u>Primary Carcinoma of Stomach</u>			
DUE TO <u>Metastasis following Rectal</u>			
(C) <u>Rectal Stricture</u>		<u>Feb 1955</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Feb 1955</u>			
19B. MAJOR FINDINGS OF OPERATION: <u>Metastatic Carcinoma</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 28, 1955</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 28, 1955</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. E. Gorman</u>		DATE SIGNED <u>July 28, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 31, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 31, 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>	



6430

07581

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

64

No.

## 1. PLACE OF DEATH:

COUNTY C aroline

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)X TOWN FederalburgLENGTH OF STAY  
(in this place)10 yearsHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSRiver Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Caroline

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN Federalburg - Rural XSTREET  
ADDRESS

(If rural, give location)

Denton Road3. NAME OF  
DECEASED:  
(Type or Print)

(First)

Silas

(Middle)

Milton

(Last)

Vick4. DATE  
OF  
DEATH

(Month)

July

(Day)

27

(Year)

1955

5. SEX:

Male6. COLOR OR  
RACE:Colored7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Single

8. DATE OF BIRTH:

January 11, 1945

9. AGE last birthday:

10

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired): Student10b. KIND OF BUSINESS OR  
INDUSTRY:  
Public School

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland12. CITIZEN OF WHAT  
COUNTRY?U.S.A.

13. FATHER'S NAME:

Silas Vick

14. MOTHER'S MAIDEN NAME:

Lottie Hawks15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)No

16. SOCIAL SECURITY No.:

None

17. INFORMANT &amp; ADDRESS:

Lottie Mason, Federalburg, Maryland, R.F.D.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

929.8  
Immediate cause(a).....  
DUE TO

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating underlying cause last(b).....  
DUE TO  
(c)Accidental DrowningINTERVAL BETWEEN  
ONSET AND DEATHfew minutesII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐21a. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING ☐  
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY 7-27-55 P. M.21e. INJURY OCCURRED  
While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Entered a deep pond22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and  
find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Lawson J. GeorgeCHIEF MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒M. D. ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

7-28-5523. BURIAL, CREMATION,  
REMOVAL (Specify):Burial

DATE THEREOF

July 31, 1955

NAME OF CEMETERY OR CREMATORY

S. Kinner's Run Cemetery

LOCATION (City, town, or county)

Near Williamsburg, Md.

(State)

DATE REC'D BY LOCAL  
REG.July 31, 1955

REGISTRAR'S SIGNATURE

Margaret H. Frampton

24. FUNERAL DIRECTOR

J.J. Frampton and Son, Federalburg, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05271

BUREAU V. S.

AUG 15 1955

RECEIVED



06488

## MARYLAND STATE DEPARTMENT OF HEALTH

6431

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 64

1. PLACE OF DEATH COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Federalsburg - Rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Denton Road</b>		STREET ADDRESS (If rural, give location) <b>Denton Road</b> /	
3. NAME OF DECEASED (Type or Print) <b>George</b> (First) <b>Robert</b> (Middle) <b>Westbrook</b> (Last)		4. DATE OF DEATH (Month) <b>July</b> (Day) <b>14</b> (Year) <b>55</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 27, 1903</b>
9. AGE last birthday <b>52</b> yrs.		10. If under 1 year Months <b>14</b> Days <b>19</b> Hours <b>55</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hobby Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Branchville, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George A. Westbrook</b>		14. MOTHER'S MAIDEN NAME <b>Katherine E. Van Auken</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Ruth L. Westbrook, Federalsburg, Md.</b>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <b>Gun shot wound in Mouth</b>		<b>Instant</b>
(b) <b>Hemorrhage</b>		<b>-</b>
(c) <b>Antecedent cause(s)</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION <b>0</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>Home</b> (CITY OR TOWN) <b>Federalsburg</b> (COUNTY) <b>Caroline</b> (STATE) <b>Md</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 14 55 10 AM</b> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR <b>Injury self inflicted</b>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE <b>Samson O George M.D.</b>	DATE SIGNED <b>7/14/55</b>
23. MARRIAGE, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>July 18, 1955</b>
NAME OF CEMETERY OR CREMATORY <b>Branchville Cemetery</b>	LOCATION (City, town, or county) (State) <b>Branchville, New Jersey</b>
DATE REC'D BY LOCAL REG. <b>July 16, 1955</b>	REGISTRAR'S SIGNATURE <b>Margaret H. Frampton</b>
24. FUNERAL DIRECTOR <b>J.J. Frampton and Son, Federalsburg, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VI 91

JUL 19 1955

RECEIVED